MISSOURI DEPARTMENT OF MENTAL HEALTH

Dorn Schuffman, Department Director

DEPARTMENT OPERATING REGULATION NUMBER
DOR 8.050

CHAPTER	SUBCHAPTER	EFFECTIVE DATE	NUMBER OF PAGES	PAGE NUMBER
Regulatory Compliance	HIPAA Regulation	June 1, 2003	3	1 of 3

SUBJECT	AUTHORITY	History
Policy and Procedures for Obtaining Authorization for the Disclosure of Protected Health Information	Section 630.050 RSMo	See Below

PERSON RESPONSIBLE	SUNSET DATE
Deputy Director, Office of Quality Management	July 1, 2006

POLICY: It is the policy of the Department of Mental Health (DMH) to protect the privacy of individually identifiable health information in compliance with federal and state laws governing the use and disclosure of protected health information and confidentiality. It is also the policy of DMH to provide for the consumer's voluntary authorization for use or disclosure of his or her protected health information (PHI) as set out in 45 CFR Sections 164.508; 164.510; and 164.512. Whether PHI may be used or disclosed is subject to the review of the Health Information Management Department (HIMD) Director, Client Information Center, or his/her designee.

APPLIES: The Department of Mental Health, its facilities and workforce.

(1) DEFINITIONS:

(A) Consumer: any individual who has received or is receiving services from a Department of Mental Health state-operated facility.

(B) Disclosure: the release, transfer, provision of access to, or divulging in any other manner of information outside the facility holding the information.

(C) Psychotherapy notes: Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and **that are separated** from the rest of the consumer's medical record. Such **notes exclude** medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress notes to date.

(2)PROCEDURE:

(A) This facility may not use or disclose protected health information without a valid authorization completed by the consumer, or applicable personal representative, with limited exceptions. The standard Department of Mental Health authorization form is attached to this DOR. The Facility Health Information Management Director (HIMD) should obtain written information regarding the identity of the requestor, the date of the request, the nature and purpose of the request and any authority that the requestor has to request such information, consistent with DOR 8.070 on Verification Procedures. If other staff receives a completed authorization form for the release of PHI, they shall direct it to the facility HIMD Director or Client Information Center representative for review.

(B) Any disclosures that occur shall be limited to the minimum amount of information necessary to meet the purpose of the use or disclosure.

1. **Exceptions** to the minimum necessary requirement are as follows:
   a. When the consumer authorizes the disclosure;
   b. Disclosures required by law.

(C) The facility **must** obtain an authorization for any use or disclosure of

psychotherapy notes **except:**

a. to carry out treatment, payment or health care operations;

b. for the facility to use in defending itself in litigation or other proceedings brought by the consumer.

(D) PHI may only be disclosed **without authorization** in the following situations:

1. To a public health authority (i.e. required reporting to the Missouri Department of Health and Senior Services);
2. To report child abuse/neglect situations, and other situations involving abuse, neglect or domestic violence (if disclosure is allowed by law);
3. To the Food and Drug Administration;
4. To a health oversight agency;
5. To judicial or administrative proceedings (a subpoena from a court is not enough);
6. To law enforcement (but only in certain circumstances; including when they present a grand jury subpoena; information concerning forensic clients; to locate a missing person, suspect, or fugitive; or at the discretion of the head of the facility when the information is requested to assist law enforcement in their investigation [see Section 630.140, Revised Statutes of Missouri]);
7. To avert a serious threat to health or safety [see also DMH Department Operating Regulation 4.410, concerning the duty to warn requirements, which are still in effect after HIPAA becomes effective April 14, 2003];
8. Governmental functions (such as national security; veterans information);
9. To other agencies administering public benefits;
10. To medical examiners and coroners;
11. To funeral directors;
12. For organ donation purposes;
13. For some research purposes; or
14. As required by law.

(3) Any questions as to whether a use or disclosure is permitted or required by law should be directed to the Facility HIMD Director, the Client Information Center representative, or the facility Privacy Officer or his/her designee.

(4) If it is the facility that requests that the consumer complete the authorization, the facility must provide the consumer with a copy of the signed authorization.

(5) LOCAL POLICIES: There shall be no facility policies pertaining to this topic. The Department Operating Regulation shall control.

(6) SANCTIONS: Any person found to have violated the requirements of this DOR shall be subject to the sanctions up to and including dismissal.

(7) REVIEW PROCESS: The Central Office Privacy Officer will collect information from the facility Privacy Officers during the month of April each year beginning in 2004 for the purpose of providing feedback to the Deputy Director, Office of Quality Management and to the Executive Team to determine the use of authorizations to disclose PHI.

History: Original DOR effective date January 1, 2003. Final DOR effective June 1, 2003.

Authorization for Disclosure of Consumer Medical/Health Information

I, _____ authorize and request
(Name of Consumer, Parent, Guardian/Legal Representative)

☐ Department of Mental Health ☐ Department of Social Services ☐ Department of Health and Senior Services
☐ Department of Elementary and Secondary Ed ☐ Other _____
(Name of indicated Facility, Agency, Mental Health Center, Person)

to **disclose/release** the below specified information of (name) _____

(date of birth): _____ (social security number) _____

who received services from _____ to _____
(Date) (Date)

to:

☐ Department of Mental Health ☐ Department of Social Services ☐ Department of Health and Senior Services
☐ Department of Elementary and Secondary Ed ☐ Other _____
(Name of indicated Facility, Agency, Mental Health Center, Person)

_____
(Address)

_____
(City, State, Zip)

The Purpose of this Disclosure is:

☐ Aftercare ☐ Placement ☐ Transfer/Treatment ☐ Treatment Planning ☐ Assessment ☐ Consumer Request
☐ Conditional/Unconditional Release Hearing ☐ Eligibility Determination ☐ Continuity of Services/Care
☐ To share information with above agencies to obtain services consistent with _____
Name of program

☐ Other specify _____

The Specific Information to be Disclosed is:

☐ Discharge Summary ☐ Treatment Plan and/or Reviews ☐ Medical/Psychiatric Assessment(s)
☐ Progress Notes ☐ Social Service Assessment
☐ For MR-DD, testing: psychometric, neurological, IQ results, or other developmental test results
☐ Educational Testing, IEP, transcript, grading reports
☐ Other _____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information: _____
3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility during the specified time frame.

4. This authorization becomes effective on _____ This authorization automatically expires on the following date, event or special condition _____

5. If I fail to specify an expiration date, this authorization will expire in one year.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **in writing** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **not** be affected.

7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

9. **THE FOLLOWING STATEMENT APPLIES TO ANY ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS THAT WE DISCLOSE:** Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

Signature of Consumer: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Signature of Parent/ Legal Guardian/Representative: _____ **Date:** _____

(Please include a Description of Authority to Act on Consumer's Behalf):

NOTICE OF REVOCATION

I, _____ (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Consumer: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Signature of Parent/ Legal Guardian/Representative: _____ **Date:** _____

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Health Information Management Director (Medical Records Director), or the Client Information Center, or to the Privacy Officer of this facility.